# MARYLAND STATE DEPARTMENT OF HEALTH

**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

9218 **CERTIFICATE OF DEATH** 09208

1

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed in 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and if any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1. **PLACE OF DEATH**
a. COUNTY: Kent — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Golt
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address):

2. **USUAL RESIDENCE** (Where deceased lived, If Institution: Residence before admission)
a. STATE: Md. b. COUNTY: Kent
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Golt
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: Ernest Middle: Last: Allen

4. **DATE OF DEATH**: Month: August Day: 1, Year: 1961

5. SEX: Male

6. COLOR OR RACE: Colored

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: March 25 1891

9. AGE (In years last birthday): 70 yrs. IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS.: Hours: Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Labor

10b. KIND OF BUSINESS OR INDUSTRY: Masonary

11. BIRTHPLACE (County & State, or foreign country): Georgia

12. CITIZEN OF WHAT COUNTRY?: U.S.A,

13. FATHER'S NAME: Lum Allen

14. MOTHER'S MAIDEN NAME: Nancy Rutter

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service):

16. SOCIAL SECURITY NO.: 221-05-2149

17. INFORMANT: Elizabeth Allen Address: Golt Md.

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Acute Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: Sudden

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 420.1

DUE TO (b): Arteriosclerosis — 3-4 yrs

DUE TO (c): degeneration of the heart muscle — 3-4 yrs

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Dey, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Sept 6, 1960 to Jul. 31, 1961 that (I) (we) last saw the deceased alive on July 4 1961, and that death occured at 11 P M, from the causes and on the date stated above.

22a. SIGNATURE: Geza Koralewski M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: Aug 2. 61

22c. PHYSICIAN'S NAME (Type): GEZA KORALEWSKI

22d. ADDRESS: MILLINGTON MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Aug. 4, 1961

23c. NAME OF CEMETERY OR CREMATORY: Dales Cemetery

23d. LOCATION (City, town or county) (State): Middletown Del.

24 FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: Edward Pellow Millington Md

25a. REC'D BY REGISTRAR DATE: AUG 7 '61

25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

# MARYLAND STATE DEPARTMENT OF HEALTH

**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

9219 **CERTIFICATE OF DEATH** 03269

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**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

**1. PLACE OF DEATH**
a. COUNTY: Kent — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Golt
c. LENGTH OF STAY IN 1b: 3yrs.
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address):

**2. USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
a. STATE: Md.
b. COUNTY: Kent
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Golt
d. STREET ADDRESS: 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒ X

**3. NAME OF DECEASED** (Type or print): First: George — Middle: S. — Last: Beatty

**4. DATE OF DEATH**: Month: Aug. — Day: 22, — Year: 1961

**5. SEX**: Male

**6. COLOR OR RACE**: White

**7. MARRIED** ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

**8. DATE OF BIRTH**: Feb.17,1870

**9. AGE** (In years last birthday): 91 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): Carpenter

**10b. KIND OF BUSINESS OR INDUSTRY**: Construction

**11. BIRTHPLACE** (County & State, or foreign country): Penna.

**12. CITIZEN OF WHAT COUNTRY?**: U.S.A.

**13. FATHER'S NAME**: George D.Beatty

**14. MOTHER'S MAIDEN NAME**: No record Yarnall

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unkown) (If yes give war or dates of service): ---

**16. SOCIAL SECURITY NO.**:

**17. INFORMANT** Address: George D. Beatty Golt Md.

**MEDICAL CERTIFICATION**

**18. CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary occlusion
DUE TO (b): Arter Sclerosis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c): Chronic myocardial

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Senility

**19. WAS AUTOPSY PERFORMED?** YES ☐ NO ☒

**20a. ACCIDENT WAS UNDERLYING** ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

**20b. DESCRIBE HOW INJURY OCCURED.** (Enter nature of injury in Part I or Part II of item 18.)

**20c. TIME OF INJURY** Hour e.m. p.m. — Month, Day, Year: 19

**20d. INJURY OCCURRED** While at work ☐ Not While at work ☐

**20e. PLACE OF INJURY** (Home, farm, factory, street, office bldg., etc.)

**20f.** (City or town) (County) (State)

**21. I certify** that (I) ~~(his hospital)~~ attended the deceased from Aug 1, 1961, to Aug 22, 1961, that (I) ~~(we)~~ last saw the deceased alive on Aug 15 1961, and that death occured at 4PM, from the causes and on the date stated above.

**22a. SIGNATURE**: C H Metcalfe M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

**22b. DATE SIGNED**: 8/23/61

**22c. PHYSICIAN'S NAME** (Type): C H METCALFE

**22d. ADDRESS**: Bel Air Md.

**23a. BURIAL, CREMATION, REMOVAL** (Spacify): Burial

**23b. DATE THEREOF**: Aug. 26, 1961

**23c. NAME OF CEMETERY OR CREMATORY**: Baptist Lower Maerion Cemetery

**23d. LOCATION** (City, town or county) (State): Bryn Mawr Pa.

**24 FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS**: Edward Pellegrini Millington Md.

**25a. REC'D BY REGISTRAR** DATE: AUG 25 '61

**25b. REGISTRAR'S SIGNATURE**: Arthur L. Kraus

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9220

## CERTIFICATE OF DEATH

09210

1. PLACE OF DEATH
a. COUNTY: Kent — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Millington. Rural - Home
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address):

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Md.
b. COUNTY: Kent
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Millington. Rural
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First: John — Middle: U. — Last: Chance

4. DATE OF DEATH: Month: August, Day: 28, Year: 1961

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]

8. DATE OF BIRTH: March, 17, 1874

9. AGE (In years last birthday): 87 yrs.
IF UNDER 1 YEAR: Months: Days:
IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer Retired.

10b. KIND OF BUSINESS OR INDUSTRY: Farming.

11. BIRTHPLACE (County & State, or foreign country): Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Daniel M. Chance

14. MOTHER'S MAIDEN NAME: Mary Chance

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give were or dates of service):

16. SOCIAL SECURITY NO.: None.

17. INFORMANT: Dudley Chance, Rural Millington, Md. (Address)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 10 days

DUE TO (b): Cerebral arteriosclerosis — years.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Senility

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work [ ] Not While at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Jan 61, 19..., to 28 Aug, 19 61, that (I) (we) last saw the deceased alive on 28 Aug 19 61., and that death occured at 2p M, from the causes and on the date stated above.

22a. SIGNATURE: Wallace Obenshain M.D.

ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]

22b. DATE SIGNED: 29 Aug 61

22c. PHYSICIAN'S NAME (Type): Wallace Garner Obenshain, M.D.

22d. ADDRESS: Cecilton, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Aug. 31, 1961

23c. NAME OF CEMETERY OR CREMATORY: Church Hill Cemetery

23d. LOCATION (City, town or county) (State): Church Hill, Md.

24. FUNERAL DIRECTOR'S SIGNATURE: Edward Fellows

ADDRESS: Millington Md.

25a. REC'D BY REGISTRAR DATE: AUG 31 '61

25b. REGISTRAR'S SIGNATURE: Arthur S. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

9221 Reg. Dist. No. 09211

1. PLACE OF DEATH
a. COUNTY: Kent — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RFD Chestertown
c. LENGTH OF STAY IN 1b: short
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Chesapeake Bay near Tolchester Beach

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Baltimore City
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore City
d. STREET ADDRESS: 6220 Brook Ave 3V01-4
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First James Middle Michael Last Cyran
4. DATE OF DEATH: Month Aug. Day 13, Year 1961
5. SEX: male
6. COLOR OR RACE: white
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 7/6/1933
9. AGE (In years last birthday): 28 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Vending Machine Co.
10b. KIND OF BUSINESS OR INDUSTRY: Employee
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Stanley J. Cyran
14. MOTHER'S MAIDEN NAME: Annabelle (Last Name Not known)

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): yes (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 212305849
17. INFORMANT: Mrs Carol Marie Cyran Address: same

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Probably Drowning — INTERVAL BETWEEN ONSET AND DEATH: Short
DUE TO (b): Boating accident in Chesapeake Bay near
DUE TO (c): Tolchester Beach (RFD Chestertown, Md.)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): boat sank
20c. TIME OF INJURY: Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED: While at work ☐ Not while at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Chesapeake Bay
20f. (City or town) Kent Co. (County) Maryland (State)

21. I certify that I taak charge of the remains described above, held an Autapsy ☐, Inspection ☒, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Hamicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: Robert W. Farr M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
EXAMINER'S NAME (Type): Robert W. Farr
DATE SIGNED: 8/16/61

22a. BURIAL, CREMATION, REMOVAL (Specify): burial
22b. DATE THEREOF: 8-18-61
22c. NAME OF CEMETERY OR CREMATORY: Baltimore National
22d. LOCATION (City, town, or county) Baltimore, Md. (State)

23. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: Leonard J. Ruck 5305 Harford Rd.
24a. REC'D BY REGISTRAR DATE: AUG 18 '61
24b. REGISTRAR'S SIGNATURE: Arthur S. Travis

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, write the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9222

## CERTIFICATE OF DEATH

Items 3 & 16 Film G294 9/13/61 iwk

03212

1 (M)

**1. PLACE OF DEATH**
a. COUNTY: Kent — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Chestertown
c. LENGTH OF STAY IN 1b: 2 hrs.
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Kent & Queen Anne's

**2. USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Kent
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chestertown
d. STREET ADDRESS: 107 High Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

**3. NAME OF DECEASED** (Type or print): First: Dee ~~Dover~~ Middle: ~~Leroy~~ Last: LeRoy Doub

**4. DATE OF DEATH**: Month: 8 Dey: 4 Yeer: 1961

**5. SEX**: Male

**6. COLOR OR RACE**: White

**7. MARRIED** ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

**8. DATE OF BIRTH**: 6/12/84

**9. AGE** (In years last birthday): 77 yrs. IF UNDER 1 YEAR: Months / Days IF UNDER 24 HRS.: Hours / Min.

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): Supervisor Steam plant-Penna. Railroad

**10b. KIND OF BUSINESS OR INDUSTRY**: Railroad

**11. BIRTHPLACE** (County & State, or foreign country): Maryland

**12. CITIZEN OF WHAT COUNTRY?**: U.S.

**13. FATHER'S NAME**: David Doub

**14. MOTHER'S MAIDEN NAME**: Alice Kenny

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unkown) (If yes give wer or dates of service): no

**16. SOCIAL SECURITY NO.**: don't know 716-07-7671

**17. INFORMANT** Address: Dover L. Doub (previous adm.) Chestertown, Md.

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**MEDICAL CERTIFICATION**

**18. CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: 1 day

DUE TO (b): Arteriosclerosis — years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c): Chronic pulmonary congestion

420.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Chronic renal insufficiency

**19. WAS AUTOPSY PERFORMED?** YES ☐ NO ☒

**20a. ACCIDENT WAS UNDERLYING** ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

**20b. DESCRIBE HOW INJURY OCCURED.** (Enter nature of injury in Part I or Part II of item 18.)

**20c. TIME OF INJURY** Hour a.m. p.m. Month, Dey, Yeer 19

**20d. INJURY OCCURRED** While at work ☐ Not While at work ☐

**20e. PLACE OF INJURY** (Home, farm, factory, street, office bldg., etc.)

**20f.** (City or town) (County) (State)

**21. I certify** that (I) ~~(this hospital)~~ attended the deceased from 8-3, 1961, to 8-4, 1961, that (I) ~~(we)~~ last saw the deceased alive on 8-4-1961 and that death occured at 9 P.M. from the causes and on the date stated above.

**22a. SIGNATURE**: Harry Paul Ross M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

**22b. DATE SIGNED**: 8-5-61

**22c. PHYSICIAN'S NAME** (Type): HARRY Paul Ross

**22d. ADDRESS**: 203 N. Queen Chestertown, Md

**23a. BURIAL, CREMATION, REMOVAL** (Specify): Burial

**23b. DATE THEREOF**: 8/8/61

**23c. NAME OF CEMETERY OR CREMATORY**: Chester Cemetery

**23d. LOCATION** (City, town or county) (State): Chestertown, Md.

**24. FUNERAL DIRECTOR'S SIGNATURE**: J Willis Wells

ADDRESS: Chestertown, Md.

**25a. REC'D BY REGISTRAR** DATE: AUG 8 '61

**25b. REGISTRAR'S SIGNATURE**: Arthur S. Kraus

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 1 Film G294 9/7/61 iwk

9223

## CERTIFICATE OF DEATH

Reg. Dist. No. 03213

1. PLACE OF DEATH
a. COUNTY KENT — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETTERTON
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Hotel Rigby

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY —
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore SV01-4
d. STREET ADDRESS 805 St. Paul Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First DAVID Middle Last FINCH

4. DATE OF DEATH Month AUGUST Day 15 Year 1961

5. SEX Male
6. COLOR OR RACE White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH August 13, 1887
9. AGE (In years last birthday) 74 yrs.
IF UNDER 1 YEAR: Months — Days —
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Night Clerk
10b. KIND OF BUSINESS OR INDUSTRY Madison Apts.
11. BIRTHPLACE (State or foreign country) Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Rowland Finch
14. MOTHER'S MAIDEN NAME Georgella Ramey

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 213-34-3377
INFORMANT A Mrs. Eleanor K. Finch Address 812 Beaumont Ave. 12

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Ventricular Fibrillation — INTERVAL BETWEEN ONSET AND DEATH 5 min
DUE TO
(b) Chronic auricular fibrillation ?
DUE TO
(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

433.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Acute pyelonephritis
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from August 14, 1961, to August 15 1961 that I last saw the deceased alive on August 14, 1961, and that death occurred at 2 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE Florence Deringer Joyce M.D.
ADDRESS (Street, city or town, state) Worton, Md.
DATE SIGNED 8-15-61
PHYSICIAN'S NAME (Type) FLORENCE DERINGER JOYCE

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 8/17/61
22c. NAME OF CEMETERY OR CREMATORY Greenmount Ave.
22d. LOCATION (City, town, or county) (State) Baltimore Md.

23. FUNERAL DIRECTOR'S SIGNATURE Wm J Tschan & Son
ADDRESS North & Ross ave Balto 17 Md
24a. REC'D BY REGISTRAR DATE AUG 17 '61
24b. REGISTRAR'S SIGNATURE Arthur J. Rivers

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/58

# MARYLAND STATE DEPARTMENT OF HEALTH

**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

9224 **CERTIFICATE OF DEATH** 09214

1

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

**1. PLACE OF DEATH**
a. COUNTY: Kent, Chestertown, MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Chestertown
c. LENGTH OF STAY IN 1b: four days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Kent and Queen Anne's Hospital

**2. USUAL RESIDENCE** (Where deceased lived, If institution, Residence before admission)
a. STATE: Maryland b. COUNTY: Queen Anne
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chestertown, R. D.
d. STREET ADDRESS: RFD 2 e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

| 3. NAME OF DECEASED (Type or print) First | Middle | Last | 4. DATE OF DEATH Month | Day | Year |
|---|---|---|---|---|---|
| Walter | H. | Hadaway, Jr. | August | 5 | 1961 |

| 5. SEX | 6. COLOR OR RACE | 7. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | IF UNDER 1 YEAR Months / Days | IF UNDER 24 HRS. Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | [X] NEVER MARRIED | December 17, 1891 | 69 yrs. | | |

| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (County & State, or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Farmer | Farming | Maryland | U. S. |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Walter H. Hadaway, Sr. | Virginia Miller |

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give wer or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT Address |
|---|---|---|
| No | 220-34-9204 | Hospital Records - Chestertown, Md. |

**MEDICAL CERTIFICATION**

**18. CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Tetanus — INTERVAL BETWEEN ONSET AND DEATH: 10 Days
DUE TO (b): 061X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [ ]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

| 20c. TIME OF INJURY Hour a.m. p.m. | Month, Day, Year 19 | 20d. INJURY OCCURRED While at work [ ] Not While at work [ ] | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) | (County) | (State) |
|---|---|---|---|---|---|---|
| | | | | | | |

21. **I certify** that (I) (this hospital) attended the deceased from 8/1, 1961, to 8/5, 1961, that (I) (we) last saw the deceased alive on 8/5 1961, and that death occured at 8:48 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Thomas J Solon M.D. — ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ] — 22b. DATE SIGNED: 8/6/61

22c. PHYSICIAN'S NAME (Type): THOMAS SOLON — 22d. ADDRESS: Chestertown, Md.

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE THEREOF | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City, town or county) | (State) |
|---|---|---|---|---|
| BURIAL | 8/8/61 | Wesley Chapel | Rock Hall | Md |

24. FUNERAL DIRECTOR'S SIGNATURE, ADDRESS: Edgar L. Lane Church Hill Md

25a. REC'D BY REGISTRAR DATE: AUG 10 '61 — 25b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9225 **CERTIFICATE OF DEATH** 09215

1 (M) I

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

**1. PLACE OF DEATH**
a. COUNTY: Kent — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chestertown
c. LENGTH OF STAY IN 1b: 3 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Kent & Queen Anne's Hospital

**2. USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Kent
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Rock Hall (rural)
d. STREET ADDRESS: RFD#1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

**3. NAME OF DECEASED** (Type or print): First: Nettie — Middle: Frances — Last: Mercer

**4. DATE OF DEATH**: Month: 8 — Day: 1 — Year: 19 61

**5. SEX**: Female

**6. COLOR OR RACE**: White

**7. MARRIED** ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

**8. DATE OF BIRTH**: 8/1/93

**9. AGE** (In years last birthday): 67 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): Housewife

**10b. KIND OF BUSINESS OR INDUSTRY**:

**11. BIRTHPLACE** (County & State, or foreign country): Maryland

**12. CITIZEN OF WHAT COUNTRY?**: U.S.A.

**13. FATHER'S NAME**: Thomas Poole

**14. MOTHER'S MAIDEN NAME**: Barbara Zellers

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unkown) (If yes give wer or dates of service): No

**16. SOCIAL SECURITY NO.**: 213 14 1221

**17. INFORMANT** Address: Mrs. Catherine Williams, Rock Hall, Md. (daughter)

**MEDICAL CERTIFICATION**

**18. CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Intracranial hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 5 days

331X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Coronary arteriosclerosis & Congestive heart failure

**19. WAS AUTOPSY PERFORMED?** YES ☐ NO ☒

**20a. ACCIDENT WAS UNDERLYING** ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

**20b. DESCRIBE HOW INJURY OCCURED.** (Enter nature of injury in Part I or Part II of item 18.)

**20c. TIME OF INJURY** Hour a.m. p.m. — Month, Day, Year 19

**20d. INJURY OCCURRED** While at work ☐ Not While at work ☐

**20e. PLACE OF INJURY** (Home, farm, factory, street, office bldg., etc.) — **20f.** (City or town) (County) (State)

**21. I certify** that (I) (this hospital) attended the deceased from 7/27, 1961, to 8/1, 1961 that (I) (we) last saw the deceased alive on 8/1/61, 19, and that death occured 10 A.M., from the causes and on the date stated above.

**22a. SIGNATURE** Robert W. Farr M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

**22b. DATE SIGNED**: Aug 1 1961

**22c. PHYSICIAN'S NAME** (Type): Robert W. Farr

**22d. ADDRESS**: Chestertown Md.

**23a.** (BURIAL) CREMATION, REMOVAL (Specify): Burial

**23b. DATE THEREOF**: Aug 3-61

**23c. NAME OF CEMETERY OR CREMATORY**: Wesley Chapel

**23d. LOCATION** (City, town or county) (State): Rock Hall Md

**24 FUNERAL DIRECTOR'S SIGNATURE**: Evelyn L. Lane — **ADDRESS**: Church Hill

**25a. REC'D BY REGISTRAR DATE**: AUG 7 '61

**25b. REGISTRAR'S SIGNATURE**: Arthur S. Mears

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

9225 — 09216 — Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Kent — MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Kent

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rock Hall

c. LENGTH OF STAY IN 1b: Short

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chestertown

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Electric Sub Station (Rock Hall)

d. STREET ADDRESS: 207 Queen St.

e. IS RESIDENCE ON A FARM? YES ☐ NO ☐ XX

3. NAME OF DECEASED (Type or print): First: C. Allie — Middle: — Last: Myers

4. DATE OF DEATH: Month: Aug. — Day: 3, — Year: 1961

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Feb. 19, 1902

9. AGE (In years last birthday): 59 yrs.

IF UNDER 1 YEAR: Months — Days

IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Electrician Mainteance

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Kent CO. Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Edwin Myers

14. MOTHER'S MAIDEN NAME: Mary Emma Brice

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): none (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 096-09-9220

17. INFORMANT: Mrs. Elise Myers — Address: Queen St. Chestertown Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): ELECTROCUTION — INTERVAL BETWEEN ONSET AND DEATH: NONE

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Accidentally touched 2400 volt line in Electric Substation

20c. TIME OF INJURY: 11 a. m. — Month, Day, Year: AUG 3 1961

20d. INJURY OCCURRED: While at work ☑ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Sub-station

20f. (City or town) ROCK HALL (County) KENT (State) MD

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☑, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE: O. S. Gulbrandsen M.D.

EXAMINER'S NAME (Type): O. S. GULBRANDSEN, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☑ Acting

DATE SIGNED: 8/3/61

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 8/5/61

22c. NAME OF CEMETERY OR CREMATORY: Chester Cemetery

22d. LOCATION (City, town, or county) Chestertown, Md. (State)

23. FUNERAL DIRECTOR'S SIGNATURE: J. Willis Wells — ADDRESS: Chestertown, Md.

24a. REC'D BY REGISTRAR DATE: AUG 7 '61

24b. REGISTRAR'S SIGNATURE: Arthur L. Travers

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, write the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9227

# CERTIFICATE OF DEATH

Reg. Dist. No. 09217

1. PLACE OF DEATH
a. COUNTY: KENT — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ROCK HALL
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND b. COUNTY: KENT
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ROCK HALL
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First AGNES Middle Last ROUSE

4. DATE OF DEATH: Month AUG. Day 6 Year 1961

5. SEX: FEM.

6. COLOR OR RACE: WHITE

7. MARRIED [ ] NEVER MARRIED [X] WIDOWED [ ] DIVORCED [ ]

8. DATE OF BIRTH: JUNE 3 - 1881

9. AGE (In years last birthday): 80 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): IOWA

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: RUBEN ROUSE

14. MOTHER'S MAIDEN NAME: ROSANNA GOODEN

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: NONE

17. INFORMANT: MRS. F.R. KENT Address: ROCK HALL MD.

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pulmonary Edema — INTERVAL BETWEEN ONSET AND DEATH:
DUE TO (b): Cardio Vascular — Unk
DUE TO (c): Arteriosclerosis

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

428.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES [ ] NO [ ]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year: Hour a. m. p. m. 19

20d. INJURY OCCURRED While at work [ ] Not while at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from July 25, 1961, to Aug 6, 1961, that I last saw the deceased alive on Aug 5, 1961, and that death occurred at 5 A.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: Norbert C Nitsch M.D. ADDRESS (Street, city or town, state): Rock Hall Md DATE SIGNED:

PHYSICIAN'S NAME (Type): NORBERT C NITSCH ROCK HALL MD

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: AUG. 9
22c. NAME OF CEMETERY OR CREMATORY: ST. JOHNS
22d. LOCATION (City, town, or county): ROCK HALL (State) MD.

23. FUNERAL DIRECTOR'S SIGNATURE: Edgar L. Lane ADDRESS: Church Hill, Md.

24a. REC'D BY REGISTRAR DATE: AUG 10 '61

24b. REGISTRAR'S SIGNATURE: Arthur S. Kent

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/5S

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

9228 — 09218

1. PLACE OF DEATH
a. COUNTY: Kent — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chestertown
c. LENGTH OF STAY IN 1b: 15 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Kent & Queen Anne's Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Kent
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chestertown (rural)
d. STREET ADDRESS: RFD#2
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Thelma — Middle: Catherine — Last: Shinnamon

4. DATE OF DEATH: Month: 8 — Day: 14 — Year: 1961

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 5/29/03

9. AGE (In years last birthday): 58 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Samuel J. Boyd

14. MOTHER'S MAIDEN NAME: Sara H. Scully

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT — Address: Thelma C. Shinnamon (Hospital records)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Pulmonary embolism, postoperative — INTERVAL BETWEEN ONSET AND DEATH: 45 minutes

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 7-30, 1961 to 8-14, 1961 that (I) (we) last saw the deceased alive on 8-14-61, 19, and that death occured at 5:25 a.m. from the causes and on the date stated above.

22a. SIGNATURE: A.C. Dick M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 8-14-61

22c. PHYSICIAN'S NAME (Type): A.C. Dick

22d. ADDRESS: Chestertown, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)

23b. DATE THEREOF: 8-17-61

23c. NAME OF CEMETERY OR CREMATORY: Kent Ridge

23d. LOCATION (City, town or county) (State): Kent Ridge, Md

24. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: McCully - Bozman Funeral

25a. REC'D BY REGISTRAR DATE: 8-16-61

25b. REGISTRAR'S SIGNATURE: Arthur L. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed in 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9229 **CERTIFICATE OF DEATH** 09219

Item 9 Film G293 8/31/61 1wk

1. PLACE OF DEATH
a. COUNTY: Kent — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Chestertown
c. LENGTH OF STAY IN 1b: 3 days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Kent & Queen Anne's Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Kent
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Rock Hall
d. STREET ADDRESS: 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Mary; Middle: Pownall; Last: Tierney

4. DATE OF DEATH: Month: 8; Dey: 26; Yeer: 1961

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 9/9/07

9. AGE (In years last birthday): 53/54 Yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Pennsylvania

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Vincent Pownall

14. MOTHER'S MAIDEN NAME: Bertha Walton

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give wer or dates of service): no

16. SOCIAL SECURITY NO.: don't know

17. INFORMANT: James J. Tierney — Address: Rock Hall, Maryland

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): 410X — Nutritional and probable electrolyte disturbance — INTERVAL BETWEEN ONSET AND DEATH: Several Weeks

DUE TO (b): due to vomiting and refusal to eat

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c): Congestive failure — 6 months

Mitral Mixed stenosis and insufficiency — Many Years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. Month, Dey, Yeer 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, ferm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 8/23/61, 19....., to 9/26/61, 19....., that (I) (we) last saw the deceased alive on 8/26/61, 19....., and that death occured 10:25 AM from the causes and on the date stated above.

22a. SIGNATURE: Robert W Farr M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 8/27/61

22c. PHYSICIAN'S NAME (Type): Robert W. Farr

22d. ADDRESS: Chestertown, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Cremation

23b. DATE THEREOF: 8/28/61

23c. NAME OF CEMETERY OR CREMATORY: Silverbrook Crematory

23d. LOCATION (City, town or county) (State): Wilmington, / Dela.

24 FUNERAL DIRECTOR'S SIGNATURE: J Willis Wells

ADDRESS: Chestertown Md / Chestertown, Md.

25a. RECD BY REGISTRAR DATE: AUG 29 '61

25b. REGISTRAR'S SIGNATURE: Arthur S. Kruse

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. (See page 4 may be required by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

# MARYLAND STATE DEPARTMENT OF HEALTH

**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

9230

## CERTIFICATE OF DEATH

Item 2 Film 6293 8/18/61 mb

03220

-ITEM #13 - SEE BIRTH CERTIFICATE

1. **PLACE OF DEATH**
a. COUNTY: KENT — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CHESTERTOWN
c. LENGTH OF STAY IN 1b: LIFETIME
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): KENT + QUEEN ANNE'S HOSPITAL

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
a. STATE: MARYLAND b. COUNTY: KENT
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X CHESTERTOWN MD. Still Pond
d. STREET ADDRESS: KENT + QUEEN ANNE'S HOSPITAL
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. **NAME OF DECEASED** (Type or print): First HARRY Middle LEWIS Last WALLEY

4. **DATE OF DEATH**: Month AUGUST Day 13 Year 1961

5. SEX: MALE

6. COLOR OR RACE: NEGRO

7. MARRIED ☐ NEVER MARRIED ☑ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: AUG 13, 1961

9. AGE (In years last birthday): ___ yrs. IF UNDER 1 YEAR: Months ___ Days ___ IF UNDER 24 HRS.: Hours 2 Min. 25

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): —

10b. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (County & State, or foreign country): KENT - MARYLAND

12. CITIZEN OF WHAT COUNTRY?: U.S BORN

13. FATHER'S NAME: LEWIS ~~WALLEY~~ WILSON

14. MOTHER'S MAIDEN NAME: MARY WALLEY

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): NO (If yes give war or dates of service): —

16. SOCIAL SECURITY NO.: NONE

17. **INFORMANT** Address: HOSPITAL RECORDS CHESTERTOWN, MD

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): FETAL ATALECTASIS — INTERVAL BETWEEN ONSET AND DEATH: 2 hrs 760h.

762.5

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): PREMATURITY (22 wks 1 lb 3 oz)

DUE TO (c): —

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): —

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.): —

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19 —

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —

20f. (City or town) (County) (State) —

21. **I certify** that (I) (this hospital) attended the deceased from AUG 13, 1961 to AUG 13, 1961, that (I) (we) last saw the deceased alive on AUG 13 1961, and that death occured at 6:15 PM, from the causes and on the date stated above.

22a. SIGNATURE: O.S. Gulbrandsen M.D.

ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 8-13-61

22c. PHYSICIAN'S NAME (Type): O.S. GULBRANDSEN, M.D.

22d. ADDRESS: CHESTERTOWN, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: 8-14-61

23c. NAME OF CEMETERY OR CREMATORY: MT. ZION CEMTY

23d. LOCATION (City, town or county) (State): STILL POND, MD.

24 FUNERAL DIRECTOR'S SIGNATURE: Victor N. Kennedy

ADDRESS: STILL POND, MD.

25a. REC'D BY REGISTRAR DATE: AUG 15 '61

25b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

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# MARYLAND STATE DEPARTMENT OF HEALTH

**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

9231

## CERTIFICATE OF DEATH

09221

**1. PLACE OF DEATH**
a. COUNTY: KENT — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): CHESTERTOWN
c. LENGTH OF STAY IN 1b: 1½ days.
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospitel, give street eddress): KENT & QUEEN ANNE'S GEN.

**2. USUAL RESIDENCE** (Where deceesed lived, If institution; Residence before edmission)
a. STATE: MD. — b. COUNTY: KENT
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CHESTERTOWN 37
d. STREET ADDRESS: 212 COURT ST. 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: DONNA — Middle: LYNN — Last: WILSON
4. DATE OF DEATH: Month: AUG. — Dey: 21 — Yeer: 1961
5. SEX: Fe.
6. COLOR OR RACE: N
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: AUG. 19, 1961
9. AGE (In yeers lest birthdey) yrs.: IF UNDER 1 YEAR Months: (1) Deys: — IF UNDER 24 HRS. Hours: 34 Min.: 42
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & Steta, or foreign country): MD.
12. CITIZEN OF WHAT COUNTRY? AM.

13. FATHER'S NAME: JESSIE - WILSON JR.
14. MOTHER'S MAIDEN NAME: NORMA JEAN BLACK
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No (If yes give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT — Address: HOSPITAL RECORDS

**MEDICAL CERTIFICATION**

18. CAUSE OF DEATH [Enter only one cause per line for (e), (b), end (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e): Foetal Atelectasis — INTERVAL BETWEEN ONSET AND DEATH
762.5
DUE TO (b): PREMATURITY
Conditions, if eny, which geve rise to immediete ceuse (a), steting the underlying ceusa lest.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(e)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20e. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Pert I or Pert II of item 18.)

20c. TIME OF INJURY: Hour e.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED While et work ☐ Not While et work ☐
20e. PLACE OF INJURY (Home, farm, fectory, straet, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 8-19-61 @ 2PM 1961 to 8-21- 6 AM 15 1961, that (I) (we) last saw the deceased alive on ..... 19..... and that death occured at 6 AM, from the causes and on the date stated above.

22a. SIGNATURE: Harry Paul Ross M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type): HARRY PAUL ROSS
22d. ADDRESS: 203 N. Queen ST Chestertown, Md

23a. BURIAL, CREMATION, REMOVAL (Spacify): Burial
23b. DATE THEREOF: 8/22/61
23c. NAME OF CEMETERY OR CREMATORY: MORGNEC CEM.
23d. LOCATION (City, town or county) (State): near Chestertown, Md.

24 FUNERAL DIRECTOR'S SIGNATURE: Kenneth Wood
ADDRESS: Chestertown, Md.
25e. REC'D BY REGISTRAR DATE: AUG 24 '61
25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

2072 141 XV 0

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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